Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Nebraska Comprehensive Program Integrity Review

Final Report

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Reviewers:
Jeff Coady, Review Team Leader
Tonya Fullen
Mark Rogers
Michael Tripp

TABLE OF CONTENTS

INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Nebraska Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Nebraska Department of Health and Human Services (DHHS). The review team also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Division of Medicaid and Long Term Care within DHHS. The Division is primarily responsible for Medicaid fee-for-service (FFS), waiver programs, managed care, payments, and provider enrollment. The program integrity operations are located within the Acute Care Programs of the Division of Medicaid and Long Term Care. This report describes six effective practices, four regulatory compliance issues, and eight vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Nebraska improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Nebraska's Medicaid Program

The DHHS administers the Nebraska Medicaid program. As of June 2009, the program served 211,010 recipients. Nebraska's FFS program had 175,239 enrolled recipients, or 83 percent of Nebraska's Medicaid population.

At the time of the review, DHHS had 22,234 participating FFS providers. Approximately 2,938 providers are participating in Nebraska's managed care organization (MCO). Medicaid expenditures in Nebraska for the State fiscal year (SFY) ending June 30, 2008, totaled $1,496,764,748. The Federal medical assistance percentage for Nebraska for Federal fiscal year 2009 was 65.74 percent.

Program Integrity Office

The Program Integrity (PI) office is the organizational component dedicated to fraud and abuse activities. At the time of the review, the PI office had approximately five full-time equivalent employees (FTEs) and two staff vacancies. Two of the five FTEs have been reassigned to work on the development and implementation of a new Medicaid Management Information System (MMIS). During SFY 2006 through SFY 2009, the PI office conducted an annual average of 29 preliminary investigations and 115 full investigations. The table below presents the total number of preliminary and full investigations, State administrative actions, and amount of overpayments identified and collected for the last four SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Number of State Administrative Actions	Amount of Overpayments Identified	Amount of Overpayments Collected
2006	18	155	183	$220.269.75	$220,269.75
2007	27	123	253	$404,428.21	$394,138.05
2008	20	105	192	$388,975.38	$378,716.06
2009	50	78	248	$343,216.81	$314,494.12

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.

Methodology of the Review

In advance of the onsite visit, the review team requested that Nebraska complete a comprehensive review guide and supply documentation in support of its answers to the review guide. The review guide included such areas as provider enrollment and disclosures, program integrity, managed care and the MFCU. A four-person review team reviewed the responses and documents that the State provided in advance of the onsite visit.

During the week of July 13, 2009, the MIG review team visited the DHHS and the MFCU offices. The team conducted interviews with numerous DHHS officials, as well as with the MFCU director. Finally, to determine whether the MCO was complying with the contract provisions and other Federal regulations relating to program integrity, the MIG review team interviewed State staff from the Nebraska Medicaid Managed Care office. The review team also reviewed the managed care contract provisions and gathered information through interviews with a representative from the MCO. In addition, the team conducted sampling of provider enrollment applications, selected claims, case files, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the DHHS. Nebraska's Children's Health Insurance Program (CHIP) operates as an expansion program under Title XIX of the Social Security Act. The expansion program operates under the same FFS billing and provider enrollment policies as Nebraska's Title XIX program. The same findings and vulnerabilities discussed in relation to the Medicaid program also apply to the CHIP program.

Unless otherwise noted, DHHS provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that DHHS provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted several practices that demonstrate its commitment to program integrity. These practices include the PI office's participation in a healthcare fraud task force, a prepayment review process for medical necessity, edits for recoupment, and a recipient lock-in program.

PI office's participation in fraud task force

Nebraska has a comprehensive healthcare fraud task force chaired by the Nebraska United States (U.S.) Attorney's Office. Members include the MFCU, CMS, U.S. Drug Enforcement Agency, U.S. Food and Drug Administration, U.S. Internal Revenue Service, Federal Bureau of Investigation, Nebraska Office of Inspector General (OIG), U.S. Postal Inspector, U.S. Department of Labor, U.S. Veterans Administration, Nebraska Public Health, Nebraska State Patrol, Nebraska Department of Insurance, and private insurance company investigators. The broad membership encourages cooperation, sharing of information, and a coordinated approach to targeting fraud, waste, and abuse.

Prepayment review process for medical necessity

The PI office conducts prepayment reviews of specific providers, procedure codes, revenue codes and diagnosis codes. Most prepayment review cases require requesting medical records from providers which are reviewed by various professionals (DHHS staff and medical consultants). This ensures that the services are medically necessary and meet all Medicaid requirements before payment is made by the State.

Edits for recoupment

If a provider is identified for repayment of funds to the State, a recoupment letter is sent. If the provider does not submit payment, or does not initiate an appeal within 30 days, an edit code is placed on the provider's number that stops claims from being adjudicated. This edit code holds payment for claims until the recovery is made.

Recipient lock-in program

Nebraska has an effective recipient lock-in program which currently includes approximately 650 recipients. Recipients that are abusing/overutilizing drugs can be restricted to one prescribing physician, one pharmacy and one hospital. The lock-in program has been successful in preventing overuse or abuse of Medicaid services. The lock-in program has helped ensure a medical home for Medicaid recipients to assure proper treatment in complex disease states. Some recipients specifically request lock-in status to rectify Medicaid identity theft situations.

Additionally, the MIG review team identified two practices that are particularly noteworthy. The CMS recognizes Nebraska's Medicaid fraud tip sheet and exemplary PI office interactions with the MFCU.

Medicaid fraud tip sheet
In a joint project with the Nebraska Senior Medicaid Program, the State has developed a Medicaid fraud tip sheet. The tip sheets are sent monthly, along with an explanation of medical benefits (EOMB), to approximately 200 random recipients. The tip sheet includes methods to protect the recipient's Medicaid benefits including the problem of signing a blank time card, medical billings, protecting personal information, and avoiding telemarketing scams. The details provided in the tip sheet help educate the recipients to aid in combating fraud, waste, and abuse.

Exemplary PI office interactions with the MFCU
The PI office and the MFCU have created a well-functioning and committed partnership between the two entities. Activities include regularly scheduled meetings as evidenced by the entities' participation in the fraud task force. The PI office and MFCU have established a clear understanding of the standards for appropriate referrals. This has resulted in the MFCU accepting almost all of the referrals from the PI office. Prior to sending a case to the MFCU, the PI office staff conducts a detailed full investigation that aids in the facilitation of the MFCU's evaluation of a case. While an investigation is being conducted by the MFCU, the PI office staff assists the MFCU by providing subject matter expertise. After the case is fully developed, the PI office and MFCU continue communication regarding the status of the case until its conclusion.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to notice of payment withholding requirements, disclosure of ownership, control, and relationship information and certain business transactions, and reporting requirements.

Nebraska's notice of payment withholding does not include all required information.
The regulation at 42 CFR § 455.23(b) stipulates that the Medicaid agency's notice of withholding state that payments are being withheld in accordance with the Federal regulation. For the State of Nebraska, the Notice of Withholding is considered to be part of the Remittance Advice (RA). The RA notifies providers who are unresponsive to repayment requests that monies owed to the State will be taken from future payments. However, the RA does not indicate that the withholding is being made in compliance with § 455.23 as required by the regulation.

Recommendation: Modify withholding letters to include language that references 42 CFR § 455.23(b) as required by the regulation.

Nebraska does not capture required ownership, control, and relationship information in its FFS operations.
Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or

controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

The State began using the Ownership/Controlling Interest and Conviction Disclosure form (MLTC-62) in April 2009 to collect required disclosures from enrolling providers. However, the Division of Developmental Disabilities (DDD), organizationally located outside of the Medicaid agency, does not use this new disclosure form. The enrollment forms used by DDD do not capture the required disclosures.

In addition, Medicaid enrollment staff that use the MLTC-62 only use the form for new Medicaid provider enrollments, and not for Medicaid provider re-enrollments.

Recommendation: Modify all provider enrollment applications to capture the required ownership, control, and relationship information. Ensure that Medicaid providers that re-enroll in the program are in compliance with 42 CFR § 455.104.

Nebraska does not require disclosure of business transactions in its FFS operations.
The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors.

The FFS provider agreements do not include a reference to 42 CFR § 455.105(b)(2) as required by the regulation. Although the provider agreements do require providers to follow policies and procedures in the Nebraska DHHS Finance and Support Manual (Title-471), the provider manual is not contractually incorporated into the provider agreement. The policies and procedures in Title-471 do not indicate that the request for business transaction information may come from the HHS Secretary as required by the regulation.

Recommendation: Modify the provider enrollment agreements to meet the requirement in 42 CFR § 455.105(b). Revise the language in Title-471 to be consistent with the regulation.

The State does not report to HHS-OIG adverse actions taken on provider applications.
The regulation at 42 CFR §1002.3(b) requires reporting to HHS-Office of Inspector General (HHS-OIG) any adverse actions a State takes on provider applications for participation in the program. The State is not submitting information to the HHS-OIG regarding actions taken on FFS and DDD applications, including the denial of initial enrollment. The PI office is not informed of enrollment denials and terminations within the DDD program.

Recommendations: Require DDD to notify the State when taking adverse action against a provider's participation in the program, including when it denies credentials for fraud-related concerns. Develop and implement procedures to report to HHS-OIG all adverse actions taken against and limits placed on providers applying to participate in the program.

Vulnerabilities

The review team identified eight areas of vulnerability in Nebraska's practices including an ineffective surveillance and utilization review (SURS) operation, not verifying recipient receipt of managed care services, not reporting local Medicaid related convictions, not reporting to HHS-OIG adverse actions taken on managed care provider applications, ineffective oversight of MCO activities, not capturing managing employee information, not conducting complete searches on excluded individuals, and not having proper edits for personal care services (PCS).

Not maintaining an effective SURS operation.
The regulation at 42 CFR § 455.13 requires a State Medicaid Agency to have methods and criteria for identifying suspected fraud cases and investigating those cases, and to have procedures for referring suspected cases of fraud to law enforcement officials.

The State has inadequate written policies and procedures for program integrity functions. Some of the policies and procedures provided by the State were not updated to be consistent with Federal regulations as evidenced in the provider enrollment procedures.

The lack of current policies and procedures limits the ability of PI office staff to effectively communicate Federal regulatory requirements to other departments delegated with program integrity responsibilities. For example, when the PI office implemented the new ownership and conviction disclosure form (MLTC-62) explaining provider responsibility to screen employees and contractors for exclusions, this was communicated via email. However, there was no evidence of updates to the policy and procedures manual to reflect the new requirements. The lack of updated written policies and procedures leaves the State vulnerable to inconsistency in its operations.

The PI office has five staff FTEs, with two FTEs currently reassigned to the development and implementation of the new MMIS. The decrease in staff has affected the ability of the PI office to be proactive in conducting investigations for referral to the MFCU. The PI office referrals to the MFCU have decreased from 44 in SFY 2006 to 13 in SFY 2008. The MFCU Director stated that the quality of cases is good; however, the quantity needs to improve.

Recommendation: Develop, compile, implement, and update written policies and procedures addressing all program integrity functions. Increase productivity in the area of investigations related to suspected fraud and possible referrals to the MFCU. Review staffing decisions to ensure sufficient staff to meet PI office needs.

Not verifying with recipients whether managed care services billed by providers were received.
Although Nebraska's FFS program utilizes EOMBs to verify with recipients whether services billed by providers have been actually received, the State's contract with the MCO does not require the MCO to conduct receipt of service verification. During the onsite interview, MCO staff confirmed they do not verify recipient receipt of services.

Recommendation: Revise the contract with the MCO to develop and implement a method for verifying with recipients whether billed services were received.

The State does not report to HHS-OIG local convictions of crimes against Medicaid.
Under the regulation at 42 CFR § 1002.230, the State Medicaid agency must provide notice to HHS-OIG within specified timeframes, unless the MFCU has already provided such notice, when an individual has been convicted of a criminal offense related to the delivery of healthcare items or services under the Medicaid program. If the State agency was involved in the investigation or prosecution, the State agency must provide notice to HHS-OIG within 15 days after conviction, and if the State agency was not involved in the investigation or prosecution, the State agency must provide notice to HHS-OIG within 15 days after learning about the conviction.

According to PI office staff, the MFCU typically reports convictions of crimes against Medicaid. However, the Memorandum of Understanding (MOU) between Nebraska DHHS and the MFCU does not address who is responsible for the reporting.

Recommendations: Institute policies and procedures that address reporting criminal convictions to HHS-OIG pursuant to 42 CFR § 1002.230. Modify the MOU with the MFCU to ensure compliance with reporting criminal convictions to HHS-OIG.

Not reporting to HHS-OIG adverse actions taken on managed care provider applications.
The regulation at 42 CFR §1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. The State Medicaid agency does not require its MCOs to inform them when the MCOs have denied enrollment or credentialing of a provider due to program integrity concerns, and the State is therefore unable to make the required report to the HHS-OIG.

Recommendation: Require MCOs to report all denials of enrollment or credentialing or terminations of providers based on program integrity concerns to DHHS.

Not maintaining adequate oversight of managed care program integrity activity.
The MCO does not communicate information concerning investigations to the State including: 1) that investigations are occurring; 2) status of investigations; 3) results of investigations; 4) overpayments recovered; and 5) referrals to other agencies. In addition, the State's contract does not require the MCO to notify the State or the HHS-OIG when the MCO initiates any action which either denies or limits the participation of a provider in the MCO's network. Finally, the MCO does not report the reasons a provider lost his credentialing status to the State nor does the MCO communicate disclosure information identified through the enrollment process to the State. The State finds out that providers are removed from the managed care program through data runs.

Recommendation: Revise the contract with the MCO to require notification to the State of actions taken on providers' credentialing status and reporting of disclosure information. Develop and implement policies and procedures for organizing periodic meetings with the MCO, requiring the MCO to report fraud, waste and abuse cases, and proactively reviewing such reports.

Not capturing managing employee information on FFS provider enrollment and managed care credentialing forms.
Under 42 CFR § 455.101, a managing employee is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency." Neither the State nor the MCO solicits managing employee information in provider enrollment or credentialing forms. Thus, the State would have no way of knowing if excluded individuals are working for providers or healthcare entities in such a role.

Recommendation: Modify FFS provider enrollment and managed care credentialing packages to require disclosure of managing employee information. Maintain such information in a database where it can be used to search for exclusions at the point of initial enrollment and periodically thereafter.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid.
The regulations at 42 CFR § 455.104 through 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply some disclosures upon request. The State does not maintain complete information on owners, officers and managing employees in the MMIS. Therefore, the State cannot conduct adequate searches of the List of Excluded Individuals/Entities (LEIE) or the Medicare Exclusion Database (the MED).

The DDD does not search providers for exclusions nor does it request appropriate disclosure information. The DDD has chosen not to use the new ownership and criminal convictions disclosure form, developed by the Medicaid agency, in its enrollment process.

Recommendation: Develop policies and procedures for appropriate collection and maintenance of disclosure information, including healthcare related criminal convictions, about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Search the LEIE or the MED upon enrollment, re-enrollment, and at least monthly thereafter, by the names of the above persons and entities.

Inability to place edits in the MMIS for PCS.
Nebraska is unable to implement any edits for PCS during inpatient stays. The PCS claims are paid through a system outside the MMIS referred to as the Nebraska Family On-line Client User System (N-FOCUS). There are no specific edits within N-FOCUS that limit PCS claims during inpatient stays. The PI office currently runs an ad hoc report to find PCS claims paid during the dates of institutional stays. The results of the review team's onsite sampling of PCS claims suggest the State may have a potential overpayment.

Recommendation: Investigate the provider claim forms and determine if additional information is available regarding the dates to rule out duplicate billing. Consider obtaining greater specificity on the dates being billed, and adopting procedures to ensure there is no duplicate billing.

CONCLUSION

The State of Nebraska applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These effective practices include:

- PI office participation in a fraud task force,
- a prepayment review process for medical necessity,
- edits for recoupment,
- a recipient lock- in program,
- a Medicaid fraud tip sheet, and
- an exemplary relationship with the MFCU

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of four areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, eight areas of vulnerability were identified. The CMS encourages DHHS to closely examine each area of vulnerability that was identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require DHHS to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Nebraska will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Nebraska has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Nebraska on correcting its areas of non-compliance, eliminating areas of vulnerability, and building on its effective practices.